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ACCESS TO DOULAS: A Bridge to Equitable Maternal Care in Texas

POLICY BRIEF BY **SAFIYAH ZAIDI**
JULY 2022

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ACKNOWLEDGMENTS

The author would like to extend her heartfelt thanks to Alyssa Beauchamp and Sonya Gurwitt for their mentorship and support for the past year. Special thanks also to Dr. Lisa Hollier, Amy Chen, Osub Ahmed, Christina Gebel, D'Andra Willis, and Michelle Sternthal for lending their valuable expertise and guidance to this project.

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EXECUTIVE SUMMARY

Texas policymakers, advocates, and mothers have long recognized the state's alarming rates of maternal mortality and morbidity—some of the highest rates in the nation. Maternal morbidity refers to any medical complications arising from pregnancy and labor, while maternal mortality refers to the pregnancy-related death of a mother. In 2013, state legislators assembled task forces charged with examining the underlying disparities in maternal health outcomes and passed legislation based on these findings (Texas MMRC 2020). Increasing access to high-quality maternal health care services in the prenatal, birthing, and postpartum periods for Texan mothers requires a solution that accounts for the unique needs of distinct communities. One policy solution to this layered challenge is to increase access to doula care, which studies show can improve maternal health outcomes and address inequities in our current health care system (Chen et al. 2021). Doulas help mothers navigate challenges specific to their communities and empower them to have a positive birthing experience (Ellmann 2020). To reinforce these efforts, Texas policymakers should support the expansion of Medicaid to include doula coverage. Expanding access to doula care will improve postpartum health management and care coordination by facilitating informational, emotional, and physical assistance. Additionally, the use of doulas is linked to significant cost savings, giving this potential policy an important economic incentive (Platt and Kaye 2020).

"The expansion of Medicaid to cover doula services presents a proven and cost-effective solution for improving maternal health care across the state, an effort that will lead to fewer maternal deaths and a more equitable health system."

Policymakers can achieve this policy solution through two primary mechanisms:

1. Tap into section 1332, or the State Innovation Waiver, of the Affordable Care Act, which funds innovative strategies proposed by states to improve health outcomes; and
2. Use a State Plan Amendment (SPA) to claim federal matching funds for a program that offers coverage of doula services.

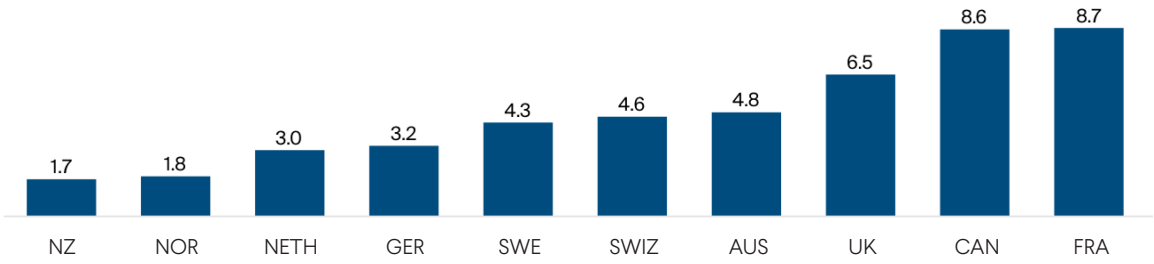
Through these policy pathways, Texas policymakers can bolster Medicaid to better respond to the needs of mothers while simultaneously reducing public spending on labor room costs. The expansion of Medicaid to cover doula services presents a proven and cost-effective solution for improving maternal health care across the state, an effort that will lead to fewer maternal deaths and a more equitable health system. This policy brief outlines how the proposed policy solution will ensure the continued health and well-being of Texas mothers and bridge inequities in maternal health outcomes.[1]

INTRODUCTION

Texas has a maternal health problem. Its maternal mortality rate is 18.5 deaths per 100,000 live births—a higher rate than all other developed, democratic countries, as shown in Figure 1 (Tikkanen et al. 2020).

FIGURE 1: MATERNAL MORTALITY RATE IN SELECTED DEVELOPED, DEMOCRATIC COUNTRIES (2018)

(Deaths per 100,000 live births)



Source: *Tikkanen et al. 2020*

[1] Note: This policy analysis uses words such as "woman," "women," or "mother." This language is not intended to be exclusionary—different categories of people, such as cisgender women and transgender men, are able to become pregnant and have children. The author's goal in this analysis is to support efforts to ensure that all pregnant and postpartum people, regardless of gender identity and expression, are able to access doula care and improve health outcomes.

Mothers of color are disproportionately affected: Black women account for 31 percent of maternal deaths, but only 11 percent of live births in Texas (Texas Maternal Mortality and Morbidity Review Committee 2020). A Texas maternal mortality and morbidity review committee also found that of all pregnancy-related deaths in Texas, about one-third occurred in the postpartum period (43 days to one year after childbirth), and nearly 90 percent of those deaths were preventable (Texas MMRC 2020). Among the leading causes of postpartum deaths are infection, drug overdoses, hemorrhage, preeclampsia, and cardiovascular conditions (Texas MMRC 2020). Access to comprehensive postpartum health care is essential to the adequate control of chronic and acute illnesses, adherence to medical recommendations, and mitigation of preventable maternal deaths and complications.

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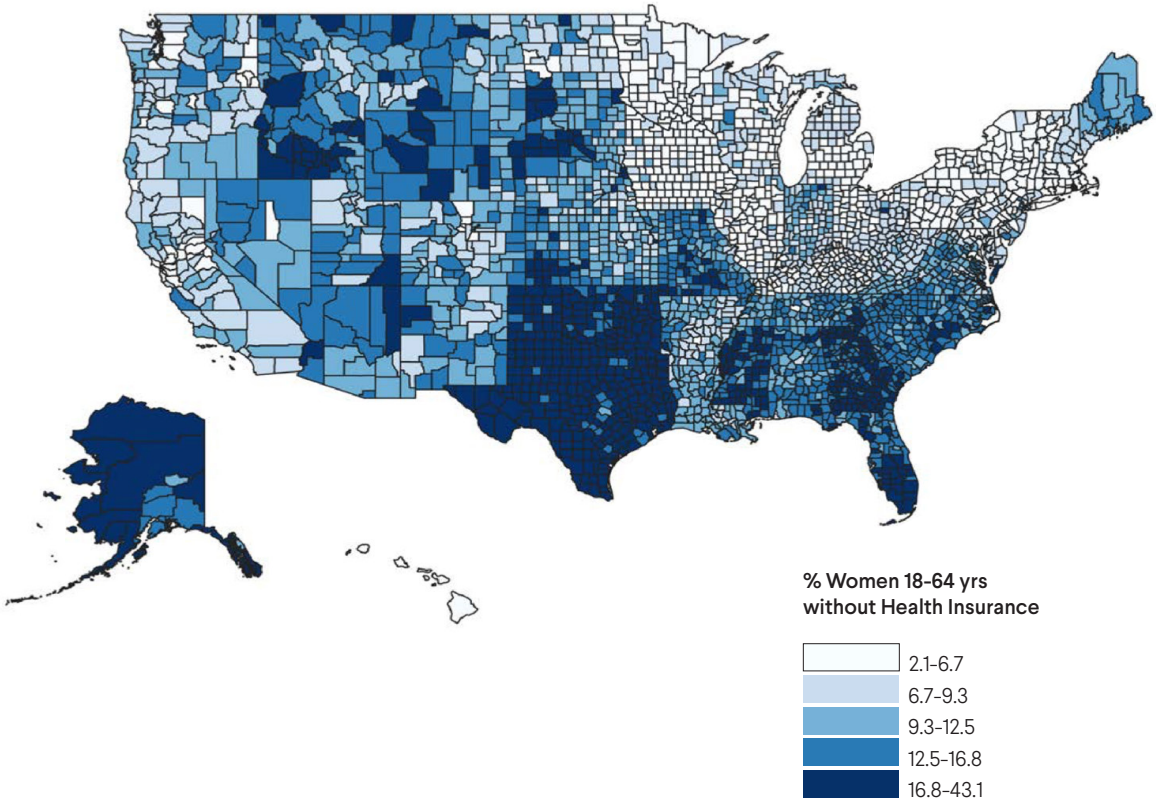
Social determinants of health (SDOH) underlie these health outcomes and disparities in Texas. SDOH encompass the range of personal, social, economic, and environmental factors that influence health status and an individual's well-being. Factors include insurance status, education, racism, and how easily someone can access health care, transportation, and nutritious food (Ellmann 2020). With a high percentage of maternal deaths in the state occurring weeks after childbirth, comprehensive postpartum care is essential to mitigate the harmful effects of SDOH and monitor health issues that can develop post-childbirth (Texas MMRC 2020).

Health insurance coverage is a critical aspect of making health care accessible and affordable for women, and is especially important during a woman's reproductive years. In this regard, Texas warrants particular consideration: The state has both the greatest overall number of uninsured citizens in the nation and the highest percentage of women in their childbearing years who lack insurance coverage (Searing and Ross 2019). Figure 2 shows the distribution of women without health insurance in the United States as of 2017; the top five counties with the greatest percentage of uninsured women are all found in Texas (March of Dimes 2020).

FIGURE 2: WOMEN LACKING HEALTH INSURANCE (2017)



Source: *March of Dimes 2020*

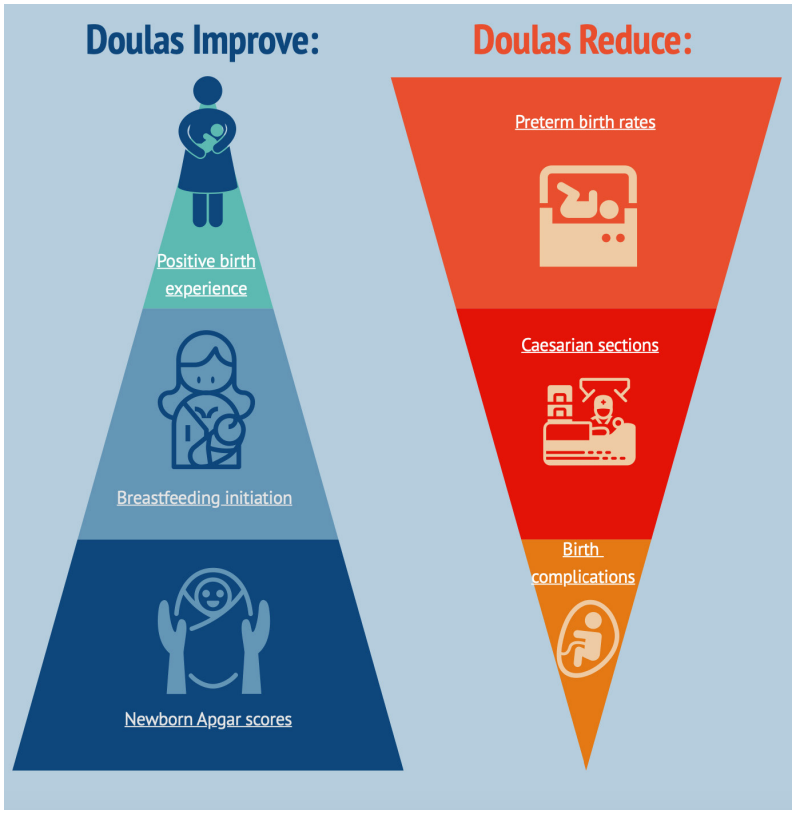
Fifty-five percent of the insured women who give birth in Texas are covered by Medicaid (Chinn et al. 2020). Although Texas has strict Medicaid income eligibility regulations, these limits are relaxed for expectant mothers, allowing more women to receive Medicaid coverage during their pregnancy and labor. However, if these mothers did

not qualify for the income eligibility requirements prior to their pregnancy, they lose their Medicaid coverage only six months after giving birth. This is especially harmful given that mothers insured through Medicaid are particularly vulnerable to health risks. To qualify for Medicaid coverage, mothers must demonstrate low-income status. A low socioeconomic status is associated with many social determinants of health that threaten a mother's health, such as lack of access to consistent prenatal and postpartum check-ups, decreased use of preventative health care, and greater frequency of chronic illness that can jeopardize a mother's health in the postpartum period (Ellmann 2020). As one-third of postpartum deaths can occur up to a year after birth, consistent postpartum visits are essential to ensure that mothers are supported in the full journey of their recovery.

"Within the maternal health landscape, pregnancy and birth doulas offer an avenue to improve birth outcomes and experiences."

Within the maternal health landscape, pregnancy and birth doulas offer an avenue to improve birth outcomes and experiences. Doulas are pregnancy and birth workers who are trained to provide nonclinical guidance and assistance to mothers throughout the prenatal, birth, and postpartum periods (Chen et al. 2021). They are distinct from midwives, who are licensed health professionals able to provide medical care, including delivering babies and performing examinations. While the support doulas provide is nonclinical, it is no less valuable. As captured by Figure 3 below, doula care is linked to better health outcomes in hospitals and birthing rooms, including fewer low-birthweight babies, preterm births, and Cesarean sections (Platt and Kaye 2020). After pregnancy, home-visiting doulas can promote maternal health by connecting mothers to postpartum medical care and emotional support resources.

FIGURE 3: THE POSITIVE IMPACT OF DOULA CARE UPON HEALTH OUTCOMES AND BIRTHING EXPERIENCES



Source: Platt and Kaye 2020

In order to address Texas' maternal mortality crisis, policymakers must begin to leverage vital doula care services. This policy brief explores:

- The history and current state of childbirth within the US;
- The factors that underlie differences in pregnancy and labor experiences;
- The critical relationship between maternal care and abortion access;
- The role of Medicaid in providing access to maternity and doula care; and
- The different ways doulas improve maternal health outcomes.

This analysis emphasizes the importance of expanding Medicaid to include doula services. Expanding Medicaid to reimburse doula care can be achieved through existing policy mechanisms within the Affordable Care Act and state legislative provisions.

HISTORY OF BIRTHING IN THE UNITED STATES

It is important to first trace the history of childbirth in America and how the current status quo emerged. The US currently employs a medicalized model of pregnancy and childbirth where the vast majority of prenatal, delivery, and postpartum care is provided by specialist physicians within hospital settings (Martucci 2017). These medical providers incorporate invasive procedures and technology, such as the use of Cesarean sections and drug interventions, as a matter of routine. However, this model of care was not always the norm: Births in the US have undergone a remarkable transition from home to hospital. In the 19th century, the use of forceps and anesthesia spread, serving as the harbinger of the medicalized era of obstetrical care in America (Johanson and Newburn 2002). The home births of early America were supplanted by hospital births overseen by male physicians wielding these newly developed medical instruments. Physicians supported the transition to hospitals because it allowed them to receive obstetric training and standardize operating procedures within a single institution (Johanson and Newburn 2002). These medical professional goals catalyzed today's standard medicalization of birth, and, in turn, the reduction of at-home births using traditional birthing assistants.

Contemporary medicalized births are useful with high-risk pregnancies that have high chances of labor complications. Access to medical technology and medically trained staff can mean the difference between life and death for mothers and infants (Johanson and Newburn 2002). However, a complete dependence on medicalization may lead to unnecessary interventions, during which mothers are encouraged to undergo procedures and tests that are not medically indicated, a term that refers to situations where a mother's health condition does not require a certain treatment or intervention (Johanson and Newburn 2002). Cesarean sections are a case study in the consequences of medicalization of birth. As of 2020, the rate of Cesarean sections in the United States is 31.8 percent; the World Health Organization recommends a rate of no more than 15 percent (World Health Organization 2015). C-sections increase the likelihood of short- and long-term adverse health outcomes for mothers and infants, such as infections, blood clots, scarring, and pelvic pain (National Partnership for Women and Families 2016). Research suggests that common labor interventions used routinely in US hospitals—such as continuous electronic fetal heartbeat monitoring, epidurals and epidural analgesia, and even instructing the mother to lie in bed instead of remaining mobile—make C-sections more likely (National Partnership for Women and Families 2016).

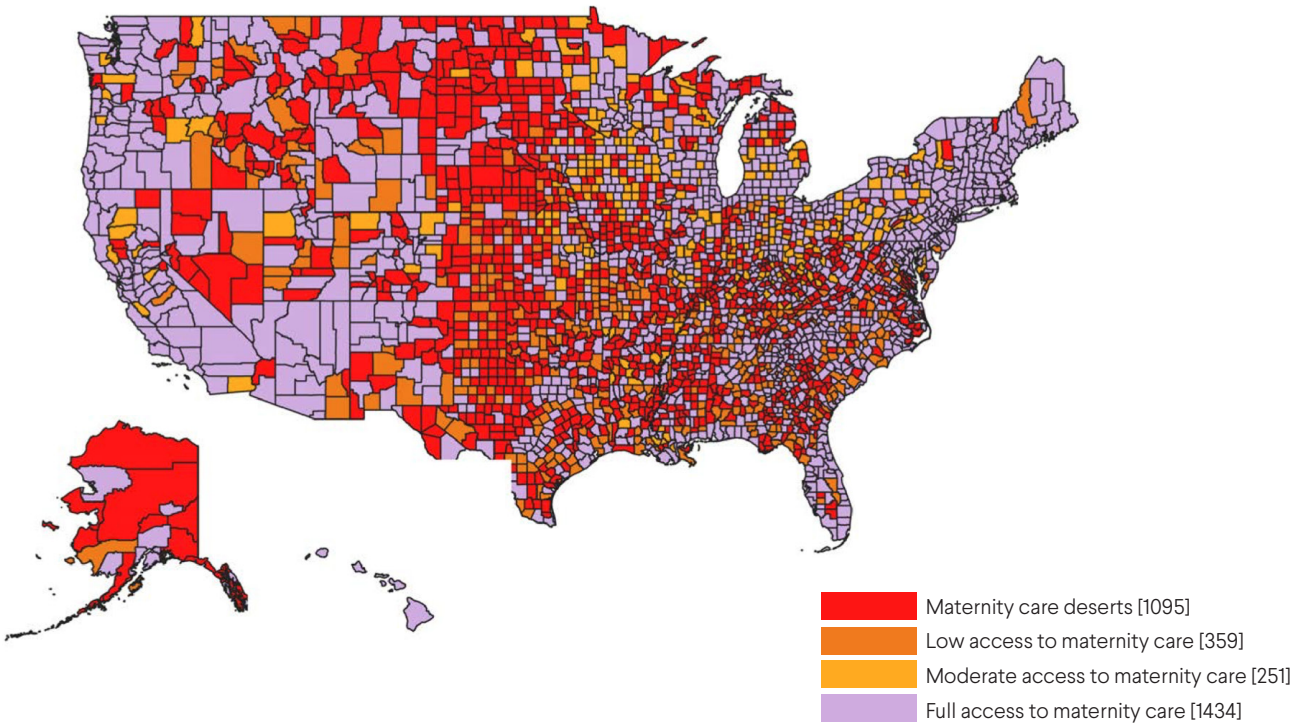
The increasing frequency of Cesarean sections reflects the US healthcare system's endorsement of an interventionist, medicalized system of labor and delivery. Critics of medicalization point to the cost of hospital births, as the ability to access this high-tech care can carry a hefty, out-of-pocket price tag of approximately $4,500, even for mothers with private insurance (Moniz 2020). Unsurprisingly, advanced medical birthing technologies have become prohibitively expensive to certain demographics and are accessed unevenly by different groups based on a host of various factors, ranging from race to socioeconomic status to location. The interacting effects of these social determinants of health lead to very different birthing experiences.

CURRENT STATE OF BIRTHING IN THE UNITED STATES

Today, labor and birthing experiences among American mothers differ dramatically. Although American women have several options for birthing settings, the vast majority choose to give birth in hospitals, with 99 percent giving birth in a hospital and only 0.52 percent giving birth in freestanding birth centers (Zephyrin 2021). However, there is wide variation in provider types and practices among hospitals and regions, leading to differential health outcomes and consequences for mothers. As such, a woman's experience varies depending on the hospital she has access to, the quality of its resources, and its level of care (National Academies of Sciences 2020).

Despite the overwhelming popularity of hospital births, this option is increasingly inaccessible for women who live in maternity care deserts. As defined by a 2020 report from March of Dimes, maternity care deserts are counties without a hospital or birth center offering obstetric care and without any obstetric providers. In the US today, approximately 2.2 million women within their childbearing years live in these deserts, and therefore lack access to adequate maternal care (March of Dimes 2020). Figure 4 displays the distribution of the 1,095 maternity care deserts in the United States, as of 2020.

FIGURE 4: MATERNITY CARE DESERTS IN THE UNITED STATES (2020)



Source: *March of Dimes 2020*

The ongoing problem of maternity care deserts is aggravated by the rise in recently shuttered rural and urban obstetric units. Hospital closings in the past decade have caused a surge in patient volume in remaining birthing care facilities and introduced a new mix of patient populations into an already stressed health care setting.

CAUSAL FACTORS AND BIRTHING EXPERIENCES

Policy solutions to the United States' maternal health crisis must be grounded in a model of reproductive justice. According to organizations such as Sister Song: Women of Color Reproductive Justice Coalition, reproductive justice advocates for the "human right to maintain personal bodily autonomy and to raise children in safe and sustainable communities" (Sister Song 2015). Such a framework recognizes that mothers of color have overlapping marginalized identities, in which systemic racism and misogyny lead to economic, education, and health inequities. To begin to account for such historic and extant barriers, policy proposals must seek to address both individual and community-level needs, which vary depending on factors like economic status, language barriers, and rural or urban geographical location, among many others.

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There is no absolute consensus on the causal factors behind the United States' dismal maternal mortality rate of 20.1 deaths per 100,000 births, but research illuminates inequities across race, socioeconomic status, and geography as major factors (Declercq and Zephyrin 2020). Researchers have found wide gaps in access to education about maternal health and access to medical services (National Partnership of Women and Families 2016). Racial discrimination in the health care system persists even when women of color reach socioeconomic and educational parity (Declercq and Zephyrin 2020). For example, compared with white women, Black women giving birth in hospital settings are more likely to report being treated unfairly and with disrespect by providers because of their race, not having final decision-making ability during labor and delivery, and feeling pressured to have a Cesarean section (Vedam et al. 2019).

Pregnancy and birthing experiences also differ depending on the mother's use of either private or public insurance. Compared to women with employer-sponsored insurance, mothers with Medicaid are more likely to report the following: an inability to access postpartum visits with medical providers; a lack of educational and emotional support during the postpartum period; the inability to make ultimate decisions during childbirth; and disrespect from insurance providers because of their Medicaid coverage (Declercq and Zephyrin 2020). Data comparing the postpartum period between mothers with private insurance versus Medicaid further captures this disparity. Seventeen percent of mothers with Medicaid lacked a consistent postpartum medical provider, while only 10 percent of mothers with private insurance did; 53 percent of mothers with Medicaid had no postpartum visits as compared to 25 percent of mothers with private insurance (Declercq et al. 2013).

Maternal health outcomes are deeply impacted by intersectionality, which refers to the understanding that a group or individual's multiple identities leads to complex combinations of privilege and discrimination, and that different social identities result in different lived experiences (Crenshaw 1989). Because pregnancy and birth experiences differ by factors such as race and socioeconomic status, policy solutions need to address these structural factors to meet the full needs of all mothers.

MATERNAL HEALTH CARE AND ABORTION

Comprehensive reproductive and maternal care includes access to safe abortion care. States that restrict or ban abortion care have greater maternal mortality than states that either protect or have not passed legislation concerning abortion (Addante et al. 2021). For more than two decades, states with a conservative legislative majority have continuously implemented legislation designed to complicate or outright block the process of accessing essential reproductive health care. Texas has consistently stood out as one of the most challenging places to obtain an abortion. The steady escalation of abortion-restricting policies reached new heights in September 2021, when Senate Bill 8 was passed (Stevenson 2021). This piece of legislation had devastating consequences for abortion care in Texas: It prohibited abortion once an ultrasound detects cardiac activity, with no exception for rape or incest, thereby making the procedure inaccessible to the overwhelming majority of abortion-seeking patients in Texas (Cohen et al. 2021). The effects of this abortion restriction will reverberate through the Texas maternal landscape. One study estimates that this abortion ban will lead to an approximately 21 percent rise in the number of overall pregnancy-related deaths, and a 33 percent increase in maternal deaths among Black mothers (Stevenson 2021). Undoubtedly, maternal morbidity and mortality rates will be exacerbated in the coming years as a result of Texas' abortion ban, which means that legislators must pay even more attention to the overall issue of maternal health across the state.

MEDICAID'S CRITICAL ROLE IN US AND TEXAS BIRTHS

Medicaid provides essential maternal care to mothers across the nation. Approximately half of births in the United States are paid for by Medicaid (National Partnership for Women and Families 2016). Provisions of the Affordable Care Act passed in 2011 expanded coverage options for women, leading to lower uninsured rates and improved access to care for women of reproductive age (Allsbrook and Ahmed 2021). These coverage gains were especially important in reducing disparities between groups of mothers navigating systemic challenges, namely Black, Indigenous, and new mothers unfamiliar with health care systems. However, the current US Medicaid landscape is varied, with eligibility and benefits fluctuating widely by state. For example, Texas is among 12 states that have not expanded Medicaid to cover more low-income residents, contributing to the state's continuously high rates of uninsured residents (Graves et al. 2020). And although Medicaid provides pregnant women with benefits, such as prenatal care and childbirth and delivery services, states have the discretion to determine additional benefits. As a result, certain states include important services such as substance use treatment and home visits within their Medicaid coverage packages. Yet even among states with expanded benefits, doula care and home births are rarely covered (Ranji et al. 2021).

To combat high rates of maternal mortality, Texas established a Maternal Mortality and Morbidity Review Committee in 2013 to study the state's health practices and issue actionable policy recommendations (MMRC 2014). Since the review committee's inception in 2013, it has steadily worked with a team of physicians and community stakeholders to issue recommendations specific to postpartum care services. In 2016, the committee urged state policymakers to extend Medicaid coverage from 60 days postpartum to 12 months in order to identify and treat health risks before they become life-threatening (MMRC 2016). After years of advocacy, a less robust version of this policy proposal was passed into law during Texas' 2021 legislative session (Waller 2021). This bill was championed by state representatives including Shawn Thierry and Toni Rose, who have long advocated for the state to take legislative action to address its high rates of maternal mortality. Working in coalitions with community organizations, such as Afiya Center and Black Mamas ATX, they successfully lobbied the state legislature to expand postpartum Medicaid coverage (Waller 2021). Starting in September 2021, Medicaid coverage will be extended from 60 days after childbirth to six months. Although any extension of coverage is a positive step, experts continue to endorse 12 months as the golden standard for postpartum care. A 12-month coverage period allows for new mothers to access the care they need to safely navigate the varied health issues that can arise in the postpartum period (Platt and Kaye 2020).

In addition to Texas Medicaid enrollees losing coverage only six months after giving birth, they are unable to access doula care services through Medicaid (Gebel and Hodin 2020). Most women who use doulas pay entirely out of pocket, as even private health plans do not cover their care. The cost for doula services ranges from several hundred dollars to over two thousand dollars (Chen et al. 2021). The prohibitive out-of-pocket cost of doula care means that not all women can access the health benefits of such care, namely much higher satisfaction with pregnancy and overall better health outcomes (Chen et al. 2021).

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Oregon and Minnesota state legislators recognize the benefits of doula care, and now provide Medicaid reimbursement for doula services. Oregon began reimbursing doula services in 2014, and Minnesota followed shortly after in the same year (Platt and Kaye 2020). The specific benefits and reimbursement rates differ according to needs and budgetary concerns, but both programs provide useful guidelines to other states looking to replicate these policies. For example, Minnesota's benefits include seven prenatal and postpartum doula sessions, one of which is labor and delivery. The reimbursement rate is $47 for prenatal or postpartum visits and $488 for labor and delivery, rates that Minnesota legislators and doulas have agreed upon as appropriate compensation (Platt and Kaye 2020). By contrast, Oregon provides two pathways: one $350 package that covers two prenatal visits, two postnatal visits, and a labor and delivery session. Another option offers four prenatal visits for $50 each and a $150 session for the labor itself (Platt and Kaye 2020).

Both states have contended with implementation challenges, and their efforts to streamline these policy ideas offer lessons for other states. For instance, Minnesota has dealt with issues related to establishing adequate reimbursement rates and collaborating with doulas (Chen et al. 2021). Policy advocates addressed these concerns by opening more channels of communication with practicing doulas and significantly increasing reimbursement rates to incentivize doulas to take on more Medicaid

patients (Chen et al. 2021). Minnesota policymakers also experimented with different models of licensing to ensure that the cost of obtaining a license would not be a barrier for those seeking to become doulas. In Oregon, doulas expressed frustration at the billing process and reimbursement rate (Chen et al. 2021), so in 2017 policymakers instituted increases in the payment rate, resulting in an increase in the number of doulas billing Medicaid. Several states—including California, Indiana, and Rhode Island—followed in Oregon and Minnesota's footsteps and passed or are currently considering legislation to allow for Medicaid reimbursement for doula services. Such state-level policy action is critical, because the high out-of-pocket cost of doulas, coupled with the lack of coverage in public and private health plans, means that many women, especially those who are low-income or on Medicaid (or both), are unable to afford important doula care.

BENEFITS AND CHALLENGES OF ACCESSING DOULA CARE

By providing wraparound support—that is, medical services and support that patients may not be able to access due to a lack of insurance or other SDOH—during the prenatal and postpartum periods, doulas improve maternal and infant health outcomes (Chen et al. 2021). Doulas improve experiences for communities most affected by discrimination and disparities in health outcomes, and offer a buffer against the harmful effects of social determinants of health, such as exploitation, exclusion, discrimination, and a loss of autonomy in the medical system (Ellmann 2020). More specifically, community-based doulas have a unique capacity to challenge bias in the medicalized birth system and build power and autonomy through relationships with individual mothers. Community-based doulas are trusted members of the communities they serve and provide care responsive to the specific needs of their community. Moreover, they can empower and support individual mothers by nurturing their emotional health, providing informational support, encouraging them to communicate their needs and preferences, and amplifying their voices in medical settings (Gebel and Hodin 2020). This reclaimed agency allows women to advocate for the birth experience they want and need.

Doula care also addresses the need to provide comprehensive postpartum care to mothers. Services offered during this critical period include helping mothers recover from childbirth complications, treating and caring for chronic health issues, and managing mental health conditions (Ranji et al. 2021). Doula care is also associated with improved maternal and infant health outcomes and lower rates of invasive medical birth interventions (Gruber et al. 2013). Multiple studies show that doula support is linked with lower rates of labor complications, lower rates of preterm birth, reduced incidences of low-birth-weight infants, and lower rates of Cesarean sections (Gruber et al. 2013).

This last benefit is particularly striking. Doulas have been shown to reduce Cesareans by anywhere from 28 percent (Hodnett et al. 2012) to 56 percent (Kozhimannil et al. 2016) for full-term births. Lowering a mother's chances of having a Cesarean section that isn't medically indicated is a critical outcome, because C-sections increase the risk of complications and chronic conditions for new mothers. Research also demonstrates that doula services can be cost saving for maternal care in the United States. In 2010, Cesarean sections cost approximately 50 percent more than vaginal births occurring in the same hospital—adding between $4,459 (Medicaid payments) to $9,537 (commercial payments) to the total cost per birth in the United States (National Partnership for Women and Families 2016). In another study, the use of doulas throughout pregnancy and labor was associated with an average of $1,000 saved per birth for Medicaid agencies (Ellmann 2020). Such cost savings are especially significant given that the United States is the most expensive country in the world in which to give birth (Ellmann 2020). Financial savings as a result of doula services are a clear incentive for state policymakers to consider this policy solution.

Finally, doulas also have a direct stake in providing abortion care, which is definitively linked to overall maternal health. One common model of doula care is to provide support to people experiencing the full range of pregnancy outcomes, including abortion. These types of doulas are called "abortion doulas," or "full-spectrum doulas," and provide support throughout a person's pregnancy journey. Such support is particularly important in Texas, as women are now required to navigate increasingly complex and high-risk situations to access abortion care or even understand their pregnancy options. It is important to consider the challenges that these doulas face in Texas in a post-Senate Bill 8 landscape. The bill empowers private citizens to sue both abortion providers and anyone whose actions could be construed as facilitating an abortion (Stevenson 2021). This provision leaves abortion doulas vulnerable to lawsuits and could potentially decrease access to doula care, because practitioners might be less willing to subject themselves to personal risk. Due to the recent passage of Senate Bill 8, there is little research monitoring the response of Texan abortion doulas, but it will be critical to watch these trends to understand the relationship between punitive abortion legislation and doula services. Nonetheless, this model of doula care demonstrates the critical wraparound services and information that doulas provide.

EXPANDING DOULA ACCESS TO INCREASE EQUITY IN TEXAS

Insurance coverage for doula services through Medicaid offers a pathway for improving birth outcomes and reducing maternal health disparities in Texas. Efforts to expand Medicaid to cover doula care will be successful only if they are designed to address clear equity disparities. It is critical that the Texas state legislature take steps to improve maternal health outcomes, as health care is a basic need that the government has an obligation to provide.

The federal government has not established consistent guidelines regulating doula care, leaving these decisions to the discretion of individual states (Gebel and Hodin 2020). As such, Texas has the ability to enact far-reaching Medicaid expansion legislation that improves health outcomes and adequately responds to the needs of pregnant individuals, ensuring that they can access doulas to support them throughout the pregnancy journey. Expanding doula coverage offers clear economic incentives: Research shows that access to doula services reduces spending on medically intensive procedures and helps avoid pregnancy and labor complications. In the United States, obstetric care has become procedure-intensive even for low-risk women and newborns, contributing to soaring maternity care costs (Moniz et al. 2020). Studies conducted in Oregon, Minnesota, and Wisconsin have found that Medicaid reimbursement of doula support has the potential to reduce Medicaid expenditures by reducing the number of unnecessary Cesareans, instrument-assisted births, and admissions to neonatal intensive care units. One model estimates that with the reduction in Cesarean sections associated with doula care, a one-time doula compensation rate of $200 would potentially save state Medicaid agencies $2 million dollars annually (Platt and Kaye 2020). Another model, shown in Table 1 below, demonstrates that the annual dollar amount of savings for Medicaid due to doula-associated reductions in C-sections would reach $646,271,408 (National Partnership for Women and Families 2016).

TABLE 1: ESTIMATED POTENTIAL REDUCTION IN SPENDING LIMITED TO CESAREANS IN THE PRESENT PREGNANCY

United States, 2013	Medicaid	Private Insurance
Number of births	1,579,099	1,845,499
Number of cesareans	517,630	642,435
Cesarean rate	32.8%	34.8%
Estimated cesareans preventable with doula support (28%)	144,936	179,882
Average additional costs per cesarean	$4,459	$9,627
Estimated savings per year	**$646,271,408**	**$1,731,722,089**
Estimated savings per birth	**$409.27**	**$938.35**

Source: *National Partnership for Women and Families 2016*

Medicaid expansion policies can help overcome challenges in maternal health care in Texas. Doula services provide a way to address health disparities, bringing long-term maternal care benefits and government cost savings to Medicaid programs. Doula care can act as a buffer against the racism systemic in maternal health institutions through access to patient-centered, culturally competent care. This is critical, as patient-centered care—defined as care that "focuses on the patient's individual's health needs . . . and empowers patients to become active participants in their own care"—results in more comprehensive care plans that serve a mother's physical, mental, and social needs (Reynolds 2009).

"Doula care can act as a buffer against the racism systemic in maternal health institutions through access to patient-centered, culturally competent care."

One mechanism by which to achieve Medicaid expansion is by leveraging opportunities in the Affordable Care Act. Section 1332 of the Affordable Care Act, known as the State Innovation Waiver, is a supplement to the legislation's principal provisions,

allowing states to pursue innovative strategies for providing residents with access to high quality health care (Schubel and Leuck 2019). States can introduce specific and tailored solutions to health problems as long as the proposals offer cost-saving benefits, do not increase the federal deficit, and do not compromise the coverage promised by the ACA. Section 1332 has been used by states for a variety of purposes, such as experimental models of employer-sponsored health insurance in Georgia and Wisconsin. In Texas, expanding doula coverage would be an ideal use of the waiver, because this policy idea matches the mission of the waiver to improve health outcomes. As discussed previously, doula care is also a substantive cost-saving measure for states in both the short and long term. Texas policymakers can leverage this waiver to firmly tackle racial disparities in health care and reduce maternal mortality through one comprehensive policy.

Another mechanism that would allow Texas to provide doula services coverage for Medicaid-enrolled pregnant women is through the use of a State Plan Amendment (SPA). An SPA is an agreement struck between the federal government and the state on how that particular state will administer Medicaid benefits and provisions (Medicaid State Plan Amendments). States must submit their state plan amendments to Centers for Medicaid and Medicare Services (CMS). If the amendment abides by federal regulations, states are able to claim federal matching funds for programs and activities designed to improve health outcomes. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the state (Medicaid State Plan Amendments). These provisions would include instructions for how each prenatal and postpartum service visit should be billed and reimbursed. Policymakers can further investigate details of reimbursement rates and frequency of doula visits by converging tasks forces and groups of stakeholders, hosting town halls to receive community feedback, and inviting written comments (Medicaid State Plan Amendments).

Policymakers in Texas should anticipate and address issues involved in expanding Medicaid to cover doula care. One concern that doulas often express is that efforts to design policies mandating doula coverage will "exclude or create barriers to practice for those trained in traditional care methods" (Ellmann 2020). Doula certification, like doula training, draws from a wide variety of doula care models, traditions, and practices; as such, states should be flexible and not require one particular certification. Standards for doula practice are determined within the community of doulas and women they support and not by state governments. Additionally, states should consider alternatives to requiring doula certification in order for doulas to be eligible for Medicaid reimbursement (Chen et al. 2021). Many doulas are trained in traditional or community-based methods of care and lack formal doula certifications. Allowing diverse pathways for doulas to meet standards of care will allow states to combat credentialism while also ensuring that only qualified individuals are allowed access to

mothers. More broadly, states should seek direct input from doulas through community engagement practices such as town halls, surveys, and a doula advisory board. Incorporating doula voices throughout the policy development process will improve the ability of doulas to properly support Medicaid-covered recipients. An ongoing relationship with doulas and policymakers further enables states to quickly address emerging issues and amend policy according to feedback from stakeholders.

To ensure that doulas can effectively aid mothers, the profession must be adequately funded by state policymakers. Policies must ensure that doulas are fairly compensated for their work at a true living wage. Successful Medicaid funded programs for doula care prioritize equitable compensation rates, fee waivers to incentivize rural doula services, and methods to diversify doula workforces through targeted recruitments (Chen et al. 2021). Such strategies allow doulas to be involved in the process of developing guidelines and protocols and ensure that mothers are being served. Lessons from pilot doula programs show that initially, some states' compensation packages were inadequate, forcing doulas to work other jobs (Platt and Kaye 2020). If doula work does not provide a living wage, the market for doula care will shrink, ultimately hurting pregnancy outcomes for women who need this care the most. States like Minnesota and Oregon have since raised their payment rates, thus highlighting the need for clear policies that compensate full-time doula care fairly.

CONCLUSION

The number of maternal deaths in the United States has steadily increased in recent decades. Texas' maternal mortality rate, one of the highest in the country, reveals significant racial disparities. Texas has also recently instituted one of the nation's most restrictive abortion laws, which, research shows, is associated with an increase in maternal mortality. The current maternal care landscape highlights the many reasons why it is crucial that policymakers support Medicaid coverage of doula services to reduce maternal mortality and morbidity rates across the state. Doula care also offers financial advantages: Studies have linked the use of doulas with birth-related cost reductions, thereby lowering the overall cost of health care expenditures by the state. By making doula services available and affordable, legislators and advocates can take meaningful action toward combating Texas' maternal health crisis. Doula care is essential in confronting systemic racism and bias that harms vulnerable communities, returning autonomy to women throughout their pregnancies and labor experiences, and saving lives.

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